Ocular Inflammatory Disease Review of Systems Questionnaire

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This is a confidential survey. Please repond to all questions.

Patient Name:_____

Address: _____

Telephone Number: _____

Referring Physician: _____

Address: _____

Telephone Number: _____

FAMILY HISTORY:

These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children or grandchildren.

Has anyone in your family had any of the following? PLEASE ANSWER YES or NO.

Cancer
Diabetes
Allergies
Arthritis or rheumatism
Syphilis
Tuberculosis
Sickle cell disease or trait
Lyme disease
Gout

Has anyone in your family had medical problems listed below? PLEASE ANSWER YES or NO.

Eyes
Skin
Kidneys
Lungs
Stomach or bowel
Nervous system or brain

SOCIAL HISTORY:

Age (Years): _____ Current job: _____

Have you lived outside the U.S.A.?
If yes, where? _____
Have you ever owned a dog?
Have you every owned a cat?

Have you ever eaten raw meat or uncooked sausage?
Have you ever had unpasteurized milk or cheese?
Have you ever been exposed to sick animals?
Do you drink untreated stream, well or lake water?
Do you smoke cigarettes?
Have you ever used intravenous drugs?
Have you ever had a bisexual or homosexual relationships?
Have you ever taken birth control pills?

PERSONAL MEDICAL HISTORY:

Are you allergic to any medications?
If yes, which medications? _____
Please list the medications that you are currently taking, including non-prescription drugs such as aspirin, Advil, antihistamines, etc.

_____
_____
_____
_____

PAST MEDICAL HISTORY:

Please list all eye operations you have had (including laser surgery), and the dates of the surgeries.

_____
_____
_____
_____
_____
_____
_____
_____

Please list all other operations that you have had and the dates of the surgeries.

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been told that you have the following conditions? PLEASE ANSWER YES or NO.

Anemia (Low Blood Counts)
Cancer
Diabetes
Hepatitis
High Blood Pressure
Pleurisy
Pneumonia
Ulcers
Herpes (cold sores)

Chicken Pox
Shingles (Zoster)
German Measles (Rubella)
Measles (Rubeola)
Mumps
Chlamydia or Trachoma
Syphilis
Gonorrhea
Any other sexually transmitted disease
Tuberculosis (TB)
Leprosy
Leptospirosis
Lyme Disease
Histoplasmosis
Candida or Moniliasis
Coccidiomycosis
Sporotrichosis
Toxoplasmosis
Toxocariasis
Cysticercosis
Trichinosis
Whipple's Disease
AIDS
Hay Fever
Allergies
Vasculitis
Arthritis
Rheumatoid Arthritis
Lupus (Systemic Lupus Erythematosus)
Scleroderma

Have you ever had any of the following illnesses? PLEASE ANSWER YES or NO.

Reiter's Syndrome
Colitis
Crohn's Disease
Ulcerative Colitis
Behcet's Disease
Sarcoidosis
Ankylosing spondylitis
Erythema Nodosa
Temporal Arteritis
Multiple Sclerosis
Serpiginous Choroidopathy
Fuchs' Heterochoromic Ididocyclitis
Vogt-Koyanagi-Harada Syndrome

Have you had any of the following symptoms in the past year? PLEASE ANSWER YES or NO.

GENERAL HEALTH:

Chills
Fevers (persistent or recurrent)
Night Sweats
Fatigue (tire easily)
Poor Appetite

Unexplained Weight Loss
Do you Feel Sick

HEAD:
Frequent or Severe Headaches
Fainting
Numbness or Tingling in your body
Paralysis in parts of your body
Seizures or Convulsions

EARS:
Hard of Hearing or Deafness
Ringing or Noises in Your Ears
Frequent or Severe Ear Infections
Painful or swollen Ear Lobes

NOSE AND THROAT:
Sores in Your Nose or Mouth
Severe or Recurrent Nosebleeds
Frequent Sneezing
Sinus Trouble
Persistent Hoaresness
Tooth or Gum Infections

SKIN:

Rashes
Skin Sores
Sunburn Easily (Photosensitivity)
White Patches of Skin or Hair
Loss of Hair
Tick or Insect Bites
Painfully Cold Fingers
Severe Itching

RESPIRATORY:

Severe or Frequent Colds
Constant Coughing
Coughing Up Blood
Recent Flu or Viral Infection
Wheezing or Asthma Attacks
Difficulty Breathing

Have you ever had any one of the following symptoms? PLEASE ANSWER YES or NO.

CARDIOVASCULAR:

Chest Pain
Shortness of breath
Swelling of your legs

BLOOD:

Frequent or Easy Bruising
Frequent or East Bleeding

Have you Received Blood Transfusions

GASTROINTESTINAL:

Trouble Swallowing
Diarrhea
Bloody Stools
Stomach Ulcers
Jaundice or Yellow Skin

BONES AND JOINTS:

Stiff Joints
Painful or Swollen Joints
Stiff Lower Back
Back Pain while Sleeping or Awakening
Muscle Aches

GENITOURINARY:

Kidney Problems
Bladder Trouble
Blood in your Urine
Urinary Discharge
Genital Sores or Ulcers
Prostatitis
Testicular Pain

Are you Pregnant?

Do you Plan to be Pregnant in the Future?